be detected with the naked eye in a little less than half the cases. The only two serious complications are bronchitis and uremia. The presence of the former has a very adverse influence upon the prognosis. Uremia is seen in about 8 per cent. of the cases. Its onset is usually early, and indeed it may be the first manifestation. The common manifestations of uremia are torpor, severe headache, nausea, vomiting, and convulsions. The convulsions occur with very little warning, and are very violent. These convulsions, if not immediately fatal, were found to be apparently of good prognosis, inasmuch as several patients made a rapid and almost complete recovery after having had severe convulsions. In the examination of the urines it was found that all cases of war nephritis showed casts, most commonly of the hyaline and granular varieties. Also, all cases showed the presence of degenerate endothelial cells. The authors regard the presence of the casts and the endothelial cells as sufficient microscopic evidence on which to diagnose this form of nephritis. The endothelial cells were found to persist in the urine after the casts have disappeared, when the patient was apparently well; 36 out of 50 cases showed red blood corpuscles in the urine, but the amount of blood did not appear to indicate the severity of the attack; 22 had albuminuria. At autopsy gross examination of the kidneys showed very little departure from the normal. Microscopic examination of the kidneys from one case showed the nephritis to be focal and not diffuse, healthy areas and diseased areas intermingled. In the latter both tubules and glomeruli were affected. Various hypotheses have been advanced as to the cause of the condition, such as damp, cold, and exposure, or fatigue from forced marches. These and others are detailed, but the authors consider that the number of causes suggested shows that the real cause is probably still unknown. However, the fact that officers and the Indian troops were comparatively immune seems significant to them. These both had a certain amount of fresh food which the other soldiers did not. The officers supplemented their canned rations by buying fresh food, while the Indian troops received fresh meat newly killed and fresh milk, not the tinned variety. The other soldiers lived practically on canned or frozen meat and condensed milk. To this diet the authors are inclined to place the cause of the war nephritis.

Trench Fever Associated with the Presence of a Hemogregarina.—Dimond (*Lancet*, September 8, 1917) announces the discovery of the presence of a small hemogregarina in the venous blood and in blood from liver, spleen, and lung punctures of a series of 12 cases of trench fever, and has further confirmed the finding in a number of cases which he has seen more recently. Study of capillary blood failed to give uniform results, so that venous blood had to be used. The organisms were found in but small numbers, even when the blood was examined upon the day or two preceding the febrile stages of the disease. The methods are given of showing up the organism and of studying its movements on the warm stage. The action of trypan red and allied substances upon the organism was watched under the microscope. In certain dilutions of trypan red there appears to be a definite slowing and even cessation of the characteristic movements of the parasite. This is also the case when trypan blue and trypaflavine are used. These dyes are being tried clinically, and already good results are shown by the use of the trypa-flavine. The cycle of development of the protozoan was studied on blood and cells derived from liver, spleen, and lung punctures. The liver appears to be the main habitat, as well as the spleen and lung, and probably bone marrow. The author believes that spleen puncture is the quickest way to make a diagnosis of trench fever. What carries the infection is undetermined, but it is suggested that the pediculus corporis or perhaps a louse parasite on rats is the agent. The close relationship of the rats and men in the trenches is in favor of this suggestion. The stomach cells of the various kinds of lice found upon the underclothing of the soldiers are at present being examined.

Some Statistical Results of the Treatment of Chest Wounds.—ELLIOTT (*Lancet*, September 8, 1917). The after-history of 170 cases of chest wounds are first considered. These patients had been transferred from France usually in the third week after the wound had been received, or a week or two later if an empyema had been drained by rib resection. The mortality from such wounds is being variously estimated at the present time, but it is certain that all deaths occur in the first month. If this period of time is survived the injury is neither of a fatal nor necessarily of a disabling character. A chest wound may invalid a soldier for two or three months if it is simple, or for any time up to a year if it has been accompanied by a large or by an infected effusion into the pleural cavity. But the ultimate recovery is very good, and few of the survivors of such wounds need to be invalided out of the army. The periods of invalidism are considered with reference to the occurrence of a sterile hemothorax, of empyema, of pneumothorax, and of lung laceration. In all the 170 cases whose histories were followed, it was very rare for any further surgical intervention to be found necessary. There was but one death, and that from an operation, undertaken at the patient's request, for the removal of a bullet. There was, in no case, any fresh effusion that required aspiration. Retained foreign bodies were seldom interfered with, and apparently caused no further trouble. Most lung wounds are accompanied by laceration of greater or less degree, but the evidence from the cases followed seems to show that laceration of the lung tissues are very readily repaired. Scar tissue quickly closes up the defect, and pneumonic inflammation or gangrene does not spread from the neighborhood of the track. A sterile hemothorax of moderate size, about 30 ounces, which does not cause much cardiac displacement, need not be aspirated. In the case of larger effusions, those which were aspirated gave tolerably good results, at least 30 per cent. of them being well again within three months. When such cases remained unaspirated, the late results have been described as being most unsatisfactory, the lung remaining collapsed and the chest expanding very poorly. The retention of foreign bodies in the chest in aseptic cases does not seem to affect recovery, but more extended information is urgently needed on this point. In cases of septic hemothorax, which had been drained in France and transferred to the United Kingdom, the period of convalescence is determined by the size of the cavity and by the nature of